Group Insurance Plan

MARICOPA COUNTY

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Home Office: Bloomfield, Connecticut
Mailing Address: Hartford, Connecticut 06152

CONNECTICUT GENERAL LIFE INSURANCE COMPANY
a CIGNA company (called CG) certifies that it insures certain Employees for the benefits provided by the following policy(s):

POLICYHOLDER: MARICOPA COUNTY

GROUP POLICY(S) — COVERAGE
2404072-01 MEDICAL EXPENSE

CERTIFICATE DATE: December 29, 1997

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.
This certificate takes the place of any other issued to you on a prior date which described the insurance.

David C Kopp
Corporate Secretary

Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

THE SCHEDULE

The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

THE SCHEDULE

DESIGNATED PROVIDER MEDICAL BENEFITS

Designated Provider Medical Benefits provide coverage for care received In-Network and Out-of-Network. To receive Designated Provider Medical Benefits, you and your Dependents may be required to pay a portion of the expenses for services and supplies. For In-Network care, that portion is the Copayment. For Out-of-Network care, that portion is the Copayment or Deductible and the Coinsurance.

Guest Privileges

If you or one of your Dependents will be residing temporarily in another location where there is a network of Participating Providers, you may be eligible for Designated Provider Medical Benefits at that location. However, the benefits available at the host location may differ from those described in this certificate. Refer to your Benefit Summary from the host location or contact your Employer for more information.

Maternity Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. This does not guarantee coverage for childbirth. Please review this Plan for further details on the specific coverage available to you and your Dependents under this Plan.

Contract Year

The term Contract Year means a period from December 29, 1997 to December 31, 1998 and January 1 to December 31 in succeeding calendar years.

THE SCHEDULE

DESIGNATED PROVIDER MEDICAL BENEFITS

Maximum Benefits

For You and Your Dependents	**This Plan Will Pay:**
Lifetime Maximum Benefit	
In-Network	Unlimited
Out-of-Network	$1,000,000
Inpatient Mental Illness, Alcohol and Drug Abuse Maximum	30 days per Contract Year
Outpatient Mental Illness, Alcohol and Drug Abuse Maximum	30 visits per Contract Year
External Prostheses Maximum	$1,000 per Contract Year
Out-of-Network Durable Medical Equipment Maximum	$700 per Contract Year
Skilled Nursing Facility Maximum	60 days per Contract Year
Outpatient Rehabilitative Therapy Maximum (other than chiropractic services)	60 visits per condition

DESIGNATED PROVIDER MEDICAL BENEFITS (Cont.)

For You and Your Dependents	**This Plan Will Pay:**
Daily Limits	
Hospital Bed and Board Daily Limit	The Hospital's negotiated daily rate for In-Network care or the Hospital's most common daily rate for a semiprivate room for Out-of-Network care
Skilled Nursing Facility Daily Limit	The Skilled Nursing Facility's negotiated daily rate for In-Network care or the Skilled Nursing Facility's most common daily rate for a semiprivate room for Out-of-Network care
Hospice Bed and Board Daily Limit	The Hospice Facility's negotiated daily rate for In-Network care or the Hospice Facility's most common daily rate for a semiprivate room for Out-of-Network care

DESIGNATED PROVIDER MEDICAL BENEFITS (Cont.)

For You and Your Dependents

Copayments/Deductibles

Copayments are expenses to be paid by you or your Dependent for the services received. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from, and are not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance.

Individual Out-of-Network Deductible	$300

Family Out-of-Network Deductible

After Out-of-Network Deductibles totaling $900 have been applied in a Contract Year for either (a) you and your Dependents or (b) your Dependents, your family need not satisfy any further Out-of-Network Deductibles for the rest of that Contract Year.

Emergency Service/Copayment

The plan covers authorized Emergency Services. You and your Dependent pay the Emergency Care Copayment shown below. For information on Emergency Services, including any waiver provisions and restrictions, refer to the section entitled ''Designated Provider Medical Benefits.''

Emergency Care Copayment for:

Physician's Office	$5 per visit
CIGNA Urgent Care Center	$20 per visit
Emergency Room	$50 per visit

DESIGNATED PROVIDER MEDICAL BENEFITS (Cont.)

For You and Your Dependents

You and your Dependent's portion of the expenses for In-Network and Out-of-Network care is as follows:

	IN-NETWORK	OUT-OF-NETWORK
For care other than for Mental Illness, Alcohol and Drug Abuse	You and your Dependent pay the In-Network Copayments below, then the Plan pays percentage shown.	You and your Dependent pay the Out-of-Network Deductible or Copayments below plus the Coinsurance, then the Plan pays percentage shown.
Office Visit for:		
Maternity	$5 for initial visit to confirm pregnancy; then 100%	Deductible, then 70%*
Surgical Procedures	100%	Deductible, then 70%*
Routine Physical & Immunization	$5 per visit, then 100%	NOT COVERED
Other (except for services below)	$5 per visit, then 100%	Deductible, then 70%*
Hospital Confinement	$0 per admission, then 100%	Deductible, then 70%*

* Refer to the section entitled ''Full Payment Area'' for further information.

DESIGNATED PROVIDER MEDICAL BENEFITS (Cont.)
For You and Your Dependents

	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility Confinement	$0 per admission, then 100%	Deductible, then 70%*
Hospice Confinement	$0 per admission, then 100%	Deductible, then 70%*
Outpatient Facility Services in Operating and Recovery Room	$0 per visit, then 100%	Deductible, then 70%*
Infertility		
Office Visit for Diagnosis	$20 per visit, then 100%	Deductible, then 70%*
Surgery (Limited Coverage)	$200 per surgery, then 100%	Deductible, then 70%*
Outpatient Rehabilitative Therapy	$5 per visit, then 100%	Deductible, then 70%*
External Prostheses	100%	$200 per Contract Year, then 70%
Durable Medical Equipment	100%	$200 per Contract Year, then 70%

* Refer to the section entitled ‘‘Full Payment Area’’ for further information.

DESIGNATED PROVIDER MEDICAL BENEFITS (Cont.)
For You and Your Dependents

	IN-NETWORK	OUT-OF-NETWORK
For Mental Illness, Alcohol and Drug Abuse	You and your Dependent pay the In-Network Copayments below, then the Plan pays percentage shown.	You and your Dependent pay the Out-of-Network Deductible or Copayments below plus any Coinsurance, then the Plan pays percentage shown.
Hospital Confinement for Mental Illness, Alcohol and Drug Abuse (other than detoxification only)	$25 per day, then 100%	NOT COVERED
Hospital Confinement solely for Detoxification	$0 per admission, then 100%	Deductible, then 70%*
Outpatient Mental Illness, Alcohol and Drug Abuse (other than for Group Therapy):		
30 Visits per Contract Year	$10 per visit, then 100%	$25 per visit, based on MCC approval*
Outpatient Group Therapy for Mental Illness, Alcohol and Drug Abuse	$5 per visit, then 100%	$25 per visit, based on MCC approval*

* Refer to the section entitled ‘‘Full Payment Area’’ for further information.

DESIGNATED PROVIDER MEDICAL BENEFITS

For You and Your Dependents

The following PAC/CSR Requirements apply to Out-of-Network Hospital admissions.

PAC/CSR REQUIREMENTS. Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the medical necessity and length of any Hospital Confinement as a registered bed patient. PAC and CSR are performed through a utilization review program by a Review Organization with which CG has contracted. PAC should be requested by you or your Dependents for each inpatient Hospital admission. CSR should be requested, prior to the end of the certified length of stay, for continued inpatient Hospital Confinement.

Expenses incurred for which benefits would otherwise be paid under this plan will not include:

- the first $300 of Hospital charges made for each separate admission to the Hospital as a registered bed patient unless PAC is received: (a) prior to the date of admission; or (b) in the case of an emergency admission, by the end of the first scheduled work day after the date of admission;
- Hospital charges for Bed and Board, during a Hospital Confinement for which PAC is performed, which are made for any day in excess of the number of days certified through PAC or CSR;
- any Hospital charges made during any Hospital Confinement as a registered bed patient: (a) for which PAC was performed; but (b) which was not certified as medically necessary.

DESIGNATED PROVIDER MEDICAL BENEFITS

For You and Your Dependents

PAC/CSR REQUIREMENTS (Continued)

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the ''Coordination of Benefits'' section.

You should start the PAC process by calling the Review Organization prior to an elective admission, or in the case of an emergency admission, by the end of the first scheduled work day after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. The Review Organization will continue to monitor the confinement until you are discharged from the Hospital. The results of the review will be communicated to you, the attending Physician, the Hospital, and CG.

The Review Organization is an organization with a staff of Registered Graduate Nurses and other trained staff members who perform the PAC and CSR process in conjunction with consultant Physicians.

THE SCHEDULE

PRESCRIPTION DRUG BENEFITS

You and your Dependent must pay a portion of Covered Prescription Drugs to receive Prescription Drug Benefits. That portion is described below.

Copayment

Copayment is that portion of Covered Prescription Drugs which you or your Dependent is required to pay under this benefit.

Participating Retail Pharmacy Copayment

For each Prescription Order $5

Participating Mail-Order Pharmacy Copayment

For each Prescription Order $10

SECTION 125 PLAN

Your Employer has agreed to provide benefits according to Section 125 of the Internal Revenue Code. A Section 125 plan is a written group insurance plan which allows Employees a choice among two or more benefits consisting of salary (cash) and non-taxable benefits. Non-taxable benefits may be in the form of salary reduction. Therefore, normally taxable salary remains Employer money and is put toward benefits tax-free.

Because your group insurance plan is a Section 125 plan, certain provisions of this certificate are superseded as described below.

No Longer in Active Service

If you return to Active Service within the same benefit plan year following your termination of employment, Section 125 plan provisions supersede the ''Eligibility - Effective Date'' section under the ''Eligibility For Employee Insurance'' provisions of your certificate as follows:

- If your insurance ceases due to your termination of employment, your Employer may allow you to become insured again for your previously selected benefits upon your return to Active Service.

Termination of Insurance Due to Failure to Pay Premium

If you fail to pay premium resulting in termination of your group insurance coverage, Section 125 plan provisions supersede the ''Eligibility - Effective Date'' section under the ''Eligibility For Employee Insurance'' provisions of your certificate as follows:

- If your insurance ceases due to your failure to pay required premium, unless you are not in Active Service due to qualified leave of absence under the Family and Medical Leave Act of 1993, you will not be permitted to elect any coverage until the next Open Enrollment Period.

In addition, due to failure to pay premium resulting in termination of your group insurance coverage, Section 125 plan provisions supersede the ''Eligibility - Effective Date'' section under the ''Late Entrant - Employee'' provisions of your certificate as follows:

- You may not enroll as a Late Entrant by providing evidence of good health, if your coverage terminates due to cancellation of your payroll deduction. You are not considered enrolled in the group insurance plan. You will not be able to select group insurance coverage until the next benefit plan year.

SECTION 125 PLAN (Continued)

Change in Family Status

Due to a change in your family status, which changes your coverage needs, you may be eligible to change your benefits. Section 125 plan provisions supersede the ''Eligibility - Effective Date'' section under the ''Eligibility For Employee Insurance'' provisions in your certificate as follows:

- You may be eligible to change your original selection of benefits when a change in your family status occurs. Consult your Employer for details.

HOW TO FILE YOUR NON-PARTICIPATING PROVIDER CLAIM

The prompt filing of any required claim form will result in faster payment of your claim.

You may get the required claim forms from your Benefit Plan Administrator. All fully completed claim forms and bills should be sent directly to your servicing CG Claim Office.

Depending on your Group Insurance Plan benefits, file your claim forms as described below.

Hospital Confinement

If possible, get your Group Medical Insurance claim form before you are admitted to the Hospital. This form will make your admission easier and any cash deposit usually required will be waived.

If you have a Benefit Identification Card, present it at the admission office at the time of your admission. The card certifies that you are insured and tells the Hospital to send its bills directly to CG.

Doctor's Bills and Other Medical Expenses

The first Medical Claim should be filed as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.

CLAIM REMINDERS

- BE SURE TO USE YOUR SOCIAL SECURITY AND ACCOUNT NUMBER WHEN YOU FILE CG'S CLAIM FORMS, OR WHEN YOU CALL YOUR CG CLAIM OFFICE.

  YOUR ACCOUNT NUMBER IS THE 7 DIGIT POLICY NUMBER SHOWN ON THE THIRD PAGE OF THIS CERTIFICATE.

- PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER PAYMENT OF YOUR CLAIMS.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

ELIGIBILITY — EFFECTIVE DATE

Eligibility for Employee Insurance

You will become eligible for insurance on the day you complete the waiting period if you are in a Class of Eligible Employees as determined by your Employer.

If you were previously insured and your insurance ceased, you must satisfy the New Employee Group Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within one year after your insurance ceased.

Initial Employee Group: You are in the Initial Employee Group if you are employed in a class of employees on the date that class of employees becomes a Class of Eligible Employees as determined by your Employer.

New Employee Group: You are in the New Employee Group if you are not in the Initial Employee Group.

Eligibility for Dependent Insurance

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Waiting Period

Initial Employee Group: None

New Employee Group: A period of time ending on the first pay period following receipt of enrollment form

Classes of Eligible Employees

Each Employee

ELIGIBILITY — EFFECTIVE DATE

Employee Insurance

This Plan is offered to you as an Employee. To be insured, you will have to pay part of the cost.

Effective Date of Your Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction form, but no earlier than the date you become eligible. If you are a Late Entrant, your insurance will not become effective until CG agrees in writing to insure you.

If you are not in Active Service on the date you would otherwise become insured, you will become insured on the date you return to Active Service.

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible; or
- you again elect it after you cancel your payroll deduction.

CG may require evidence of good health at your expense if you are a Late Entrant.

ELIGIBILITY - EFFECTIVE DATE

Dependent Insurance

For your Dependents to be insured, you will have to pay part of the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form, but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

If you are a Late Entrant for Dependent Insurance, the insurance for each of your Dependents will not become effective until CG agrees in writing to insure that Dependent.

Dependent Medical Insurance for any one of your Dependents who is a patient in a Hospital on the date his insurance would otherwise become effective will be postponed until the day after he is discharged.

Your Dependents will be insured only if you are insured.

Late Entrant - Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 30 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction.

CG may require evidence of your Dependent's good health at your expense if you are a Late Entrant.

Exception for Newborns

Any Dependent child born while you are insured for Medical Insurance will become insured for Medical Insurance on the date of his birth if you elect Dependent Medical Insurance no later than 31 days after his birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

REQUIREMENTS OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1993 (OBRA'93)

These health coverage requirements do not apply to any benefits for loss of life, dismemberment or loss of income.

Any other provisions in this certificate that provide for: (a) the definition of an adopted child and the effective date of eligibility for coverage of that child; and (b) eligibility requirements for a child for whom a court order for medical support is issued; are superseded by these provisions required by the federal Omnibus Budget Reconciliation Act of 1993, where applicable.

A. Eligibility for Coverage under a Qualified Medical Child Support Order

If a Qualified Medical Child Support Order is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child as soon as reasonably possible.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction, and satisfies all of the following requirements:

1. the order specifies your name and last known address, and the child's name and last known address;
2. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
3. the order states the period to which it applies; and
4. the order specifies each plan that it applies to.

The Qualified Medical Child Support Order may not require the health insurance policy to provide coverage for any type or form of benefit not otherwise provided under the policy.

B. Eligibility for Coverage for Adopted Children

Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the "Exceptions for Newborns" section of this certificate that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

Any "Pre-existing Condition Limitation" in this certificate will be waived for an adopted child or a child placed for adoption.

EFFECT OF INTERACTION WITH HEALTH MAINTENANCE ORGANIZATIONS

The following provisions apply to the interaction between the insurance under the policy and membership in any Health Maintenance Organization (called HMO) offered by your Employer.

Eligibility For Insurance

If you are enrolled in an HMO you cannot be insured for the Employee Insurance or the Dependent Insurance under the policy while you keep your HMO membership, but you can elect the insurance based on the Transfer Provisions.

Transfer Provisions

If you are a member of an HMO you may transfer to the plan of insurance under the policy for yourself and your Dependents based on the following:

(1) If you enroll during a Group Enrollment Period, you will become insured for yourself and your Dependents on the last day of the Group Enrollment period except as provided under (4).

(2) If a Qualified HMO ceases to operate, you may elect the insurance for yourself and your Dependents on or before the date membership in the HMO ends. The effective date of the insurance will be the date membership in the HMO ends.

(3) You may elect the insurance for yourself and your Dependents on or before the date membership in a Qualified or Non-Qualified HMO ends because of your relocation outside the HMO's service area. The effective date of the insurance will be the date membership in the HMO ends, except as provided in item (4).

(4) In the case of a transfer from membership in a Non-Qualified HMO, the insurance will become effective as stated above unless:

- you are not in Active Service on that day. In this instance, it will become effective on the date you return to Active Service.
- any one of your Dependents is a patient in a Hospital on that day. In this instance, the effective date of the insurance for you and your Dependents will be postponed until the day after your Dependent is discharged from the Hospital.

EFFECT OF INTERACTION WITH HEALTH MAINTENANCE ORGANIZATIONS

(5) If you or any one of your Dependents is Confined in a Hospital on the effective date of a transfer from a Qualified HMO, you may cancel the election of the insurance until the next Group Enrollment Period. You must notify your Employer of this cancellation within 7 days of what would have been the date of transfer.

(6) If a Qualified HMO, due to bankruptcy, cannot offer medical service for which it is responsible, CG will allow you and any one of your Dependents to transfer to the insurance under the policy as of the date the Qualified HMO fails to meet its obligation.

(7) Provisions regarding a Pre-existing Condition will not apply to a person who:

- transfers from a Qualified HMO to insurance under the policy; or
- transfers from a Non-Qualified HMO to insurance under the policy because of your relocation outside the HMO's service area.

(8) If your Dependents are members of the HMO, you must also transfer them to the insurance under the policy.

Termination Provisions

If you join an HMO, your insurance under the policy for yourself and your Dependents will cease on the effective date of your membership in the HMO. No payment will be made for any expenses incurred for Injury or Sickness after that date; except that the Medical Benefits Extension will apply to you and your Dependents if the HMO has a waiting period or Pre-existing Condition limitation which prevents receipt of benefits on the effective date of your HMO membership.

Maximum Benefit Provision

The total amount of Medical Benefits payable for all expenses incurred by a person in his lifetime will not exceed the Maximum Benefit shown in The Schedule, in spite of any interruption of that person's insurance.

EFFECT OF INTERACTION WITH HEALTH MAINTENANCE ORGANIZATIONS DEFINITIONS

Group Enrollment Period

A Group Enrollment Period is a 10-day period when you may choose one of the medical plans which your Employer offers. The plans offered would include:

- the Employee Insurance and Dependent Insurance under the policy, and
- membership in an HMO operating in the area where you live.

This Group Enrollment Period is held annually during the 10 days before the policy Anniversary Date. However, CG, your Employer, and the HMO may agree on a different arrangement.

Qualified HMO

A federally Qualified HMO means a Health Maintenance Organization, as approved by the Secretary of Health and Human Services which qualifies under Title XIII of the Public Health Service Act as added by the Health Maintenance Organization Act of 1973 and its Amendments.

Non-Qualified HMO

Non-Qualified HMO means a Health Maintenance Organization which either:

- has not applied for approval under the Health Maintenance Organization Act of 1973; or,
- has not yet been found, by the Secretary of Health and Human Services, to qualify under Title XIII of the Public Health Service Act as added by the Health Maintenance Organization Act of 1973 and its Amendments.

IMPORTANT INFORMATION ABOUT YOUR MEDICAL PLAN

Details of your medical benefits are described on the following pages.

Primary Care Physician

Choice of Primary Care Physician:

When you elect Medical Insurance, you will select a Primary Care Physician for yourself and your Dependents from a list provided by the Provider Organization. The Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents.

Primary Care Physician's Role/Your Responsibility:

The Primary Care Physician's role is to provide or arrange for medical care for you and any of your Dependents.

You and your Dependents are responsible for contacting and obtaining the authorization of the Primary Care Physician, as required, prior to seeking medical care. (You are responsible for obtaining such authorization on behalf of a Dependent who is a minor.)

Changing Primary Care Physicians:

You may request a transfer from one Primary Care Physician to another through the Provider Organization. Any such transfer will be effective on the first day of the month following the month in which the Provider Organization completes the processing of the change request.

In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, you or your Dependent will be notified for the purpose of selecting a new Primary Care Physician.

DIRECT ACCESS FOR OB/GYN SERVICES:

Female insureds covered by this plan are allowed direct access to a licensed/certified participating practitioner for covered ob/gyn services. There is no requirement to obtain an authorization of care from your Primary Care Physician for visits to the participating practitioner of your choice for pregnancy, well-woman gynecological exams, primary and preventive gynecological care, and acute gynecological conditions.

DESIGNATED PROVIDER MEDICAL BENEFITS

For You and Your Dependents

If you or any one of your Dependents, while insured for these benefits, incurs Covered Expenses or any other expenses described below, CG will pay an amount determined as follows for the expenses so incurred, subject to the Maximum Benefit Provision; provided that any amount payable for or in connection with treatment of mental illness, alcohol or drug abuse will be determined by the Mental Illness, Alcohol or Drug Abuse section, except for Hospital Confinement solely for detoxification.

100% of the Covered Expenses incurred for charges for Emergency Services, provided that: (a) the Emergency Services are received from or pre-authorized by the person's Primary Care Physician; or (b) the Emergency Services are not so pre-authorized, but are authorized by the Provider Organization after receipt of timely notice, within 48 hours of admission in the case of Hospital Confinement or as soon as reasonably possible. Services for an initial screening examination, immediately necessary stabilization, and ambulance service when provided by an Arizona provider not contracted or employed by CIGNA, are payable at the Out-of-Network level, without prior authorization. Before benefits are payable, the applicable Emergency Care Copayment shown in The Schedule will be deducted from such Covered Expenses, except that the Emergency Room Copayment will be waived if the person becomes Confined in a Hospital due to that Injury or Sickness;

100% of the Covered Expenses incurred for In-Network charges related to a standard model hearing aid.

DESIGNATED PROVIDER MEDICAL BENEFITS

100% of the following expenses incurred for In-Network care other than Emergency Services, after first deducting the applicable In-Network Copayment shown in The Schedule from such expenses incurred for the service received:

Covered Expenses incurred for charges made by, or authorized care arranged by a Participating Provider;

Expenses incurred for vision and hearing screenings provided by the Primary Care Physician for persons age 17 and under;

Expenses incurred for charges made by a Participating Provider for: (a) routine care of a newborn Dependent child prior to discharge from the Hospital nursery; (b) routine physical examinations; and (c) immunizations;

100% of the In-Network or Out-of-Network Covered Expenses incurred for Durable Medical Equipment or for external prostheses subject to the maximums shown in The Schedule, if any, and provided that: (a) the applicable In-Network Copayment shown in The Schedule, if any, will first be deducted from the In-Network Covered Expenses so incurred for the person in each Contract Year; and (b) the applicable Out-of-Network Copayment shown in The Schedule will first be deducted from the Out-of-Network Covered Expenses so incurred for the person in each contract year;

70% of all other Covered Expenses incurred for Out-of-Network care, after first deducting the Out-of-Network Deductible shown in The Schedule from such other Covered Expenses incurred for the person in each contract year.

DESIGNATED PROVIDER MEDICAL BENEFITS

Full Payment Area

When a person has incurred $6,000 of Covered Expenses in a Contract Year for which no payment is provided because of the Out-of-Network coinsurance factor, exclusive of any Deductible or any Copayments, benefits for him for Covered Expenses incurred during the rest of that Contract Year will be payable at the rate of 100%.

When either (a) you and your Dependents or (b) your Dependents have incurred a combined amount of Covered Expenses of $6,000 in a Contract Year for which no payment is provided because of the Out-of-Network coinsurance factor, exclusive of any Deductible or any Copayments, benefits for you and all of your Dependents for Covered Expenses incurred during the rest of that Contract Year will become payable at the rate of 100%.

However, Out-of-Network benefits for Covered Expenses incurred for or in connection with outpatient mental illness, alcohol or drug abuse will not be increased by the terms of this Full Payment Area.

All Copayments will continue to apply.

Maximum Benefit Provision (Out-of-Network)

The total amount of Out-of-Network Medical Benefits payable for all expenses incurred during a person's lifetime will not exceed the Out-of-Network Maximum Benefit shown in The Schedule. However, once a person uses any portion of his Out-of-Network Maximum Benefit, on each January 1, CG will reinstate the used amount up to $1,000 to be applied to Covered Expenses incurred after the date of reinstatement.

Mental Illness, Alcohol and Drug Abuse Maximums

Mental illness, alcohol and drug abuse benefits are managed through MCC Managed Behavioral Care, Inc. (MCC).

The total number of days for which In-Network benefits are payable for expenses incurred in any Contract Year while a person is Confined in a Hospital due to mental illness, alcohol or drug abuse will not exceed any Inpatient Maximums as shown in The Schedule for those causes. Hospital Confinement solely for detoxification does not count toward any such maximum.

The total number of visits for which benefits are payable for expenses incurred in any Contract Year due to mental illness, alcohol or drug abuse while a person is not Confined in a Hospital will not exceed any Outpatient Maximums as shown in The Schedule for those causes. Visits for treatment of mental illness which qualify as group therapy do not count toward any maximum number of visits shown in The Schedule for mental illness.

DESIGNATED PROVIDER MEDICAL BENEFITS

Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are essential for the necessary care and treatment of an Injury or a Sickness.

Covered Expenses

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made by a Skilled Nursing Facility, on its own behalf, for medical care and treatment; except that for any day of Skilled Nursing Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Skilled Nursing Facility Limit shown in The Schedule; nor will benefits be payable for more than the maximum number of days shown in The Schedule.
- charges made by a facility licensed or certified to furnish mental health services, on its own behalf, for care and treatment of mental illness provided on an outpatient basis.
- charges made by a facility licensed or certified to furnish treatment of alcohol and drug abuse, on its own behalf, for care and treatment provided on an outpatient basis.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse, other than a member of your family or your Dependent’s family, for professional nursing service.

DESIGNATED PROVIDER MEDICAL BENEFITS

Covered Expenses (Continued)

- charges made for anesthetics and their administration; diagnostic X-ray and laboratory examinations; X-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration; rental or, at CG's option, purchase of Durable Medical Equipment; therapy provided by a licensed physical, occupational or speech therapist; and drugs and medicines while Confined in a Hospital;
- charges made for or in connection with approved organ transplant services, including immunosuppressive medication; organ procurement costs; and donor's medical costs. The amount payable for donor's medical costs will be reduced by the amount payable for those costs from any other Plan. Certain transplants will not be covered based on General Limitations. Contact CG before you incur any such costs;
- charges made in connection with mammograms for breast cancer screening performed on dedicated equipment for diagnostic purposes on referral by a patient's Physician, not fewer than; (a) a baseline mammogram for women age 35 to 39, inclusive; (b) a mammogram for women age 40 to 49, inclusive, every two years or more frequently based on the attending Physician's recommendation; or (c) a mammogram every year for women age 50 and over;
- charges made by a Home Health Care Agency for any home health care service which a Physician has prescribed in place of Hospital service, provided the service would qualify as a Covered Expense if performed in a Hospital;

DESIGNATED PROVIDER MEDICAL BENEFITS

Covered Expenses (Continued)

- charges for the purchase, maintenance or repair of internal prosthetic medical appliances consisting of permanent or temporary internal aids and supports for defective body parts; specifically intraocular lenses, artificial heart valves, cardiac pacemakers, artificial joints, intrauterine devices and other surgical materials such as screw nails, sutures, and wire mesh; excluding all other prostheses;
- charges for two external breast prostheses incidental to a mastectomy; (The Copayments and Maximums for external prostheses do not apply to breast prostheses.)
- charges for initial purchase and fitting of external prosthetic devices which are used as a replacement or substitute for a missing body part and are necessary to alleviate or correct Sickness, Injury or congenital defect; including only artificial arms and legs and terminal devices such as a hand or hook. Replacement of such prostheses is covered only if needed due to normal body growth;
- charges incurred at birth for the delivery of a child only to the extent that they exceed the birth mother's coverage, if any, provided: a) that child is legally adopted by you within one year from date of birth; b) you are legally obligated to pay the cost of the birth; c) you notify CG of the adoption within 60 days after approval of the adoption or a change in the insurance policies, plans or company; and d) you choose to file a claim for such expenses subject to all other terms of these Medical Benefits;
- charges for a standard model hearing aid, or examination for prescription or fitting thereof; subject to deductible and coinsurance Out-of-Network.

Covered Expenses (Continued)

- charges made for a person who has been diagnosed as having six months or fewer to live due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:
    - by a Hospice Facility for Bed and Board and Services and Supplies, except that, for any day of confinement in a private room, Covered Expenses will not include that portion of charges which is more than the Hospice Bed and Board Limit shown in The Schedule;
    - by a Hospice Facility for services provided on an out-patient basis;
    - by a Physician for professional services;
    - by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling, including bereavement counseling within one year after the person's death;
    - for pain relief treatment, including drugs, medicines and medical supplies;
    - by a Home Health Care Agency for:
        - part-time or intermittent nursing care by or under the supervision of a Nurse;
        - part-time or intermittent services of a Home Health Aide;

DESIGNATED PROVIDER MEDICAL BENEFITS

Covered Expenses (Continued)

- physical, occupational and speech therapy;
- medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following charges for Hospice Care Services are not included as Covered Expenses:

- for the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- for any period when you or your Dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the policy;
- for services or supplies that are primarily to aid you or your Dependent in daily living;
- for more than three bereavement counseling sessions.

DESIGNATED PROVIDER MEDICAL BENEFITS

Covered Expenses (Continued)

- charges for Alternative Medicine. This benefit offers up to 6 visits (without a referral) to CIGNA's Designated Alternate Medicine Network for services which might not be standardly covered under the Medical Program.

  Included are: Physician exam & management; Physical Medicine; Acupuncture/Acupressure; Homeopathic Consultation; Biofeedback/guided imagery; Herbal and/or Homeopathic products as prescribed in conjunction with an office visit & subsequently dispensed at a Designated Alternative Medicine Center, not to exceed $60 retail value for all products combined per benefit year.

  Alternate Medicine treatment and services are covered when provided or performed at Designated Alternative Medicine Centers (facilities with Physicians and practitioners with which CHC has contracted to provide Alternative Medicine Services).

  Alternative Medicine Services provided to a participant by a facility, Physician, or practitioner that is not a CIGNA HealthCare designated Alternative Medicine Center will not be covered or reimbursed by the Healthplan.

  Alternative Medicine Benefits include ONLY those services described and provided within 6 self-referral visits per year. To schedule an appointment the member should contact one of the providers shown below:

  Southwest Naturopathic Medical Center
  Naturopathic Family Care
  Deer Valley Health Care Center

DESIGNATED PROVIDER MEDICAL BENEFITS

Expenses Not Covered

Covered Expenses will not include, and no payment will be made for, expenses incurred:

- for or in connection with cosmetic surgery unless (a) a person receives an Injury, while insured for these benefits, which results in bodily damage requiring the surgery; or (b) it qualifies as reconstructive surgery performed on a person following the surgery, and both the surgery and the reconstructive surgery are essential and medically necessary.
- for eyeglasses, however, Covered Expenses will include the purchase of the first pair of contact lenses that follows cataract surgery.
- for hearing aid charges in excess of standard model.
- for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for: (a) charges made for or in connection with dental work due to an Injury to sound natural teeth sustained while a person is insured for these benefits; or (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; or (c) charges made by a Free-Standing Surgical Facility or the outpatient department of a Hospital in connection with surgery.
- for transsexual surgery, including hormonal therapy.
- for In-Network routine physical examinations not required for health reasons including, but not limited to, employment, insurance, government license, court ordered, forensic or custodial evaluations; and for any Out-of-Network routine physical examinations unless otherwise specified in this section.
- for which benefits are not payable according to the ''General Limitations'' section; except that the limitations with respect to a maximum for multiple surgical procedures, an allowable charge for an assistant surgeon or co-surgeon and covered providers being family members will not apply to In-Network care.

DESIGNATED PROVIDER MEDICAL BENEFITS

Expenses Not Covered (Continued)

Covered Expenses will not include, and no payment will be made for, expenses incurred:

- for rehabilitative therapy by a licensed physical, occupational or speech therapist, on an outpatient basis, which is provided for any one condition more than 60 consecutive days after the date of the first such treatment for that condition. (This limitation does not apply to medically necessary spinal manipulation, treatment of structural imbalance and distortion/subluxation of the vertebrae.)
- for therapy to improve general physical condition, including, but not limited to, cardiac rehabilitation and pulmonary rehabilitation.
- for replacement of external prostheses due to wear and tear, loss, theft or destruction; or for any biomechanical external prosthetic devices.
- for penile prostheses.
- for organ procurement costs that are not directly related to procurement of an organ from a cadaver or a donor having a blood relationship with the recipient.
- for prescription drugs or medicines while not Confined in a Hospital.
- for Out-of-Network Inpatient Mental Health, Alcohol and Drug Abuse.

DESIGNATED PROVIDER MEDICAL BENEFITS

Expenses Not Covered (Continued)

- for Out-of-Network care for or in connection with an Injury or a Sickness which is a Pre-existing Condition after benefits equal to $750 have become payable, unless those expenses are incurred after a twelve-month period during which a person is continuously insured for these benefits.

  Late Entrant - A Late Entrant will be excluded from coverage for a Pre-existing Condition until that person has been continuously insured for these benefits for a period of 18 months.

Pre-Existing Condition

A Pre-existing Condition is an Injury or a Sickness for which a person receives treatment, incurs expenses or receives a diagnosis from a Physician during the 90 days prior to the date that person becomes insured for these benefits. The term Pre-existing Condition will also include any condition which is related to any such Injury or Sickness. The Pre-existing Condition Limitation will not apply to a newborn who was otherwise covered from the time of birth.

Credit for Coverage Under Prior Policy

If a person was previously covered under another group medical policy or self-insured group medical plan, a credit of one month shall be given for each month of continuous coverage under the prior plan. Continuous coverage means that no more than 60 days has elapsed between coverage under a prior group medical plan and coverage under this plan, exclusive of any waiting period.

PRESCRIPTION DRUG BENEFITS

If you or any one of your Dependents, while insured for these benefits, incurs expenses for charges made by a Pharmacy for Covered Prescription Drugs for an Injury or a Sickness, CG will pay that portion of the expense remaining after you or your Dependent has paid the required Copayment shown in the Schedule.

No payment will be made under any other section for expenses incurred to the extent that benefits are payable for those expenses under this section.

Covered Prescription Drugs

The term Covered Prescription Drugs means:

- a Prescription Legend Drug for which a written prescription is required;
- oral or injectable insulin dispensed only upon the written prescription of a Physician;
- insulin needles and syringes;
- a compound medication of which at least one ingredient is a Prescription Legend Drug;
- tretinoin for individuals through age 26;
- any other drug which, under the applicable state law, may be dispensed only upon the written prescription of a Physician;
- oral contraceptives or contraceptive devices, regardless of intended use, except that implantable contraceptive devices, such as Norplant, are not considered Covered Prescription Drugs;
- prenatal vitamins, upon written prescription;
- colostomy supplies;
- glucose test strips; and
- an injectable drug, excluding injectable infertility drugs, for which a prescription is required, including needles and syringes.

PRESCRIPTION DRUG BENEFITS (Continued)

Limitations

No payment will be made for expenses incurred:

- for nonlegend drugs, other than those specified under ‘‘Covered Prescription Drugs’’;
- to the extent that payment is unlawful where the person resides when expenses are incurred;
- for charges which the person is not legally required to pay;
- for charges which would not have been made if the person were not covered by these benefits;
- for experimental drugs or for drugs labeled: ‘‘Caution - limited by federal law to investigational use’’;
- for drugs which are not considered essential for the necessary care and treatment of an Injury or Sickness, as determined by Connecticut General Life Insurance Company or RxPRIME;
- for drugs obtained from a non-Participating Mail Order Pharmacy;
- for any prescription filled in excess of the number specified by the Physician or dispensed more than one year from the date of the Physician’s order;
- for more than a 30-day supply when dispensed in any one Prescription Order through a Retail Pharmacy;
- for more than a 90-day supply when dispensed in any one Prescription Order through a Participating Mail Order Pharmacy;
- for indications not approved by the Food and Drug Administration;

PRESCRIPTION DRUG BENEFITS (Continued)

- for a brand-name drug to the extent that the charge for the brand-name drug exceeds the charge for a comparable FDA ''A-rated'' generic, (this limitation does not apply if the Physician requests the brand-name drug and specifies ''Dispense as Written'' on the Prescription Order);
- for immunization agents, biological sera, blood or blood plasma;
- for therapeutic devices or appliances, syringes, support garments and other nonmedicinal substances;
- for drugs used for cosmetic purposes;
- for tretinoin for individuals age 27 and over;
- for administration of any drug;
- for medication which is taken or administered, in whole or in part, at the place where it is dispensed or while a person is a patient in an institution which operates, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
- for prescriptions which an eligible person is entitled to receive without charge from any workers' compensation or similar law or any public program other than Medicaid;
- for growth hormones and anabolic steroids;
- for nutritional or dietary supplements, antiobesity drugs or anorexients;
- for vitamins;
- for oral infertility drugs;
- for smoking cessation products.

PRESCRIPTION DRUG BENEFITS (Continued)

Reimbursement/Filing a Claim

If you or your Dependent purchases Covered Prescription Drugs from a Participating Retail Pharmacy, you pay only the portion shown in the Schedule at the time of purchase. You do not need to file a claim form.

If you or your Dependent purchases Covered Prescription Drugs from a non-Participating Retail Pharmacy, you pay the full cost at the time of purchase. You must submit a claim form in order to be reimbursed for the amount payable by the plan.

If you or your Dependent purchases Covered Prescription Drugs from a Participating Mail-Order Pharmacy, you should refer to your ''Mail-Order Drug Introductory Kit'' for details.

You may obtain the required claim form from your Benefit Plan Administrator. All claim forms should be completed by you.

The section in your certificate entitled ''How to File a Claim'' does not apply to Prescription Drug Benefits.

MEDICAL CONVERSION PRIVILEGE

For You And Your Dependents

When a person's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy). A Converted Policy will be issued by CG only to a person who is Entitled to Convert, and only if he applies in writing and pays the first premium for the Converted Policy to CG within 31 days after the date his insurance ceases. Evidence of good health is not needed.

Employees Entitled To Convert

You are Entitled To Convert Medical Expense Insurance for yourself and all of your Dependents who are insured when your insurance ceased, except a Dependent who is eligible for Medicare or would be Overinsured, but only if:

- Your insurance ceased because:
  - you were no longer in Active Service or
  - you were no longer eligible for Medical Expense Insurance.
- You are not eligible for Medicare.
- You would not be Overinsured.

If you retire you may apply for a Converted Policy within 31 days after your retirement date in place of any continuation of your insurance that may be available under this plan when you retire, if you are otherwise Entitled to Convert.

Dependents Entitled To Convert

The following Dependents are also Entitled to Convert:

- a child whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse whose insurance under this plan ceases due to divorce, annulment of marriage or your death;
- your Dependents, if you are not Entitled to Convert solely because you are eligible for Medicare;

but only if that Dependent: (a) was insured when your insurance ceased; (b) is not eligible for Medicare; and (c) would not be Overinsured.

MEDICAL CONVERSION PRIVILEGE

Overinsured

A person will be considered Overinsured if either of the following occurs:

- His insurance under this plan is replaced by similar group coverage within 31 days.
- The benefits under the Converted Policy, combined with Similar Benefits, result in an excess of insurance based on CG's underwriting standards for individual policies. Similar Benefits are: (a) those for which the person is covered by another hospital, surgical or medical expense insurance policy, or a hospital, or medical service subscriber contract, or a medical practice or other prepayment plan or by any other plan or program; or (b) those for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or (c) those available for the person by or through any state, provincial or federal law.

Converted Policy

The Converted Policy will be one of CG's current offerings at the time the first premium is received based on its rules for Converted Policies. It will comply with the laws of the jurisdiction where the group medical policy is issued. However, if the applicant for the Converted Policy resides elsewhere, the Converted Policy will be on a form which meets the conversion requirements of the jurisdiction where he resides. The Converted Policy offering may include medical benefits on a group basis. The Converted Policy need not provide major medical coverage unless it is required by the laws of the jurisdiction in which the Converted Policy is issued.

MEDICAL CONVERSION PRIVILEGE

Converted Policy (Continued)

The Converted Policy will be issued to you if you are Entitled to Convert, insuring you and those Dependents for whom you may convert. If you are not Entitled to Convert and your spouse and children are, it will be issued to the spouse, covering all such Dependents. Otherwise, a Converted Policy will be issued to each Dependent who is Entitled to Convert. The Converted Policy will take effect on the day after the person's insurance under this plan ceases. The premium on its effective date will be based on: (a) class of risk and age; and (b) benefits.

The Converted Policy may not exclude any pre-existing condition not excluded by this plan. During the first 12 months the Converted Policy is in effect, the amount payable under it will be reduced so that the total amount payable under the Converted Policy and the Medical Benefits Extension of this plan will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan.

CG or the Policyholder will give you, on request, further details of the Converted Policy.

GENERAL LIMITATIONS
MEDICAL BENEFITS

No payment will be made for expenses incurred for you or any one of your Dependents:

- for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit;
- for or in connection with a Sickness which is covered under any workers' compensation or similar law;
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Sickness or Injury;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- to the extent that they are more than Reasonable and Customary Charges;
- for charges for unnecessary care, treatment or surgery, except as specified in any certification requirement shown in The Schedule;
- for or in connection with Custodial Services, education or training;
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- for experimental drugs or substances not approved by the Food and Drug Administration, or for drugs labeled: ''Caution - limited by federal law to investigational use'';
- for or in connection with experimental procedures or treatment methods not approved by the American Medical Association, or the appropriate medical specialty society;

- to the extent of the exclusions imposed by any certification requirement shown in The Schedule;
- for charges made by a Physician for or in connection with surgery which exceed the following maximum when two or more surgical procedures are performed at one time: the maximum amount payable will be the amount otherwise payable for the most expensive procedure, and 1/2 of the amount otherwise payable for all other surgical procedures;
- for or in connection with in vitro fertilization, artificial insemination or similar procedures.

- for charges made by an assistant surgeon in excess of 20 percent of the surgeon's allowable charge; or for charges made by a cosurgeon in excess of the surgeon's allowable charge plus 20 percent (for purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts);
- for charges made for or in connection with the purchase or replacement of contact lenses; except, the purchase of the first pair of contact lenses that follows cataract surgery will be covered;
- for charges made for or in connection with routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn;
- for charges for supplies, care, treatment or surgery which are not considered essential for the necessary care and treatment of an Injury or Sickness, as determined by CG;
- for charges made for or in connection with tired, weak or strained feet for which treatment consists of routine footcare, including but not limited to, the removal of calluses and corns or the trimming of nails unless medically necessary;
- for or in connection with speech therapy, if such therapy is: (a) used to improve speech skills that have not fully developed; (b) can be considered custodial or educational; or (c) is intended to maintain speech communication; speech therapy which is not restorative in nature will not be covered;
- for charges made by any covered provider who is a member of your family or your Dependent's family.

No payment will be made for expenses incurred by you or any one of your Dependents to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with:

- a ‘‘no-fault’’ insurance law; or
- an uninsured motorist insurance law.

CG will take into account any adjustment option chosen under such part by you or any one of your Dependents.

MEDICARE ELIGIBLES

The Medical Insurance for a person who is eligible for Medicare will be modified as follows:

> The amount payable under this plan will be reduced so that the total amount payable by CG and Medicare will be no more than 100% of the expenses incurred. This provision will not apply to a person while Medicare, based on the rules established by the Social Security Act of 1965 as amended, is assuming the role of secondary payer to this plan for that person.

CG will assume the amount payable under:

- Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied.
- Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him.

COORDINATION OF BENEFITS

If you or any one of your Dependents is covered under more than one Plan, benefits payable from all such Plans will be coordinated. All of the benefits from this plan are subject to Coordination of Benefits except those medical services authorized by the Provider Organization which are identified on a list available from the Provider Organization.

Coordination of Benefits will be used to determine the benefits payable for a person for any Claim Determination Period if, for the Allowable Expenses incurred in that Period, the sum of:

(a) the benefits that would be payable from this Plan in the absence of coordination; and

(b) the benefits that would be payable from all other Plans without Coordination of Benefits provisions in those Plans;

would exceed such Allowable Expenses.

The benefits that would be payable from this Plan for Allowable Expenses incurred in any Claim Determination Period in the absence of Coordination of Benefits will be reduced to the extent required so that the sum of:

(a) those reduced benefits; and

(b) all the benefits payable for those Allowable Expenses from all other Plans;

will not exceed the total of such Allowable Expenses. Benefits payable from all other Plans include the benefits that would have been payable had proper claim been made for them.

However, the benefits of another Plan will be ignored when the benefits of this Plan are determined if: (a) the Benefit Determination Rules would require this Plan to determine its benefits before that Plan; and (b) the other Plan has a provision that coordinates its benefits with those of this Plan and would, based on its rules, determine its benefits after this Plan.

COORDINATION OF BENEFITS

CG reserves the right to release to or obtain from any other Insurance Company or other organization or person any information which, in its opinion, it needs for the purpose of Coordination of Benefits.

When payments which should have been made under this Plan based on the terms of this section have been made under any other Plans, CG will have the right to pay to any organizations making these payments the amount it determines to be warranted. Amounts paid in this manner will be considered to be benefits paid under this Plan. CG will be released from all liability under this Plan to the extent of these payments. When an overpayment has been made by CG at any time, it will have the right to recover that payment, to the extent of the excess, from the person to whom it was made or any other Insurance Company or organization, as it may determine.

Plan

Plan means any of the following which provides medical or dental benefits or services: (a) group, blanket or franchise insurance coverage; (b) service plan contracts, group or individual practice or other prepayment plans; or (c) coverage under any: labor-management trusteed plans; union welfare plans; employer organization plans; or employee benefit organization plans. Plan does not include coverage under individual policies or contracts. Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Allowable Expense

Allowable Expense means any necessary, reasonable and customary item of expense, at least a part of which is covered by any one of the Plans that covers the person for whom claim is made. When the benefits from a Plan are in the form of services, not cash payments, the reasonable cash value of each service is both an Allowable Expense and a benefit paid. Allowable Expense will not include the difference between: (a) the cost of a private room; and (b) the cost of a semiprivate room; except while the person's stay in a private room is medically necessary in terms of generally accepted medical practice.

Claim Determination Period

Claim Determination Period means a calendar year or that part of a calendar year in which the person has been covered under this Plan.

COORDINATION OF BENEFITS

Benefit Determination Rules

The rules below establish the order in which benefits will be determined:

(1) The benefits of a Plan which covers the person for whom claim is made other than as a dependent will be determined before a Plan which covers that person as a dependent.

(2) The benefits of a Plan which covers the person for whom claim is made as a dependent of a person whose day of birth occurs first in a calendar year will be determined before a Plan which covers that person as a dependent of a person whose day of birth occurs later in that year; except that: (a) if the other Plan does not have this rule, its alternate rule will govern; and (b) in the case of a dependent child of divorced or separated parents, the rules in item (3) will apply.

(3) If there is a court decree which establishes financial responsibility for medical, dental or other health care of the child, the benefits of the Plan which covers the child as a dependent of the parent so responsible will be determined before any other plan; otherwise:

(a) The benefits of a Plan which covers the child as a dependent of the parent with custody will be determined before a Plan which covers the child as a dependent of a stepparent or a parent without custody.

(b) The benefits of a Plan which covers the child as a dependent of a stepparent will be determined before a plan which covers the child as a dependent of the parent without custody.

COORDINATION OF BENEFITS

Benefit Determination Rules (Continued)

(4) When the above rules do not establish the order, the benefits of a plan which has covered the person for whom claim is made for the longer period of time will be determined before a Plan which has covered the person for the shorter period of time; except that:

(a) The benefits of a Plan which covers the person as a laid-off or retired employee, or his dependent will be determined after a Plan which covers the person as an employee, other than a laid-off or retired employee, or his dependent.

(b) If the other Plan does not have the rule in item (4)(a), which results in each Plan determining its benefits after the other, then item (4)(a) will not apply.

PAYMENT OF BENEFITS

To Whom Payable

All Medical Benefits are payable to you. However, at the option of CG and with the consent of the Policyholder, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

If any person to whom benefits are payable is a minor or, in the opinion of CG, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, CG may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, CG may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

Payment as described above will release CG from all liability to the extent of any payment made.

Time of Payment

Benefits will be paid by CG when it receives due proof of loss.

Recovery of Overpayment

When an overpayment has been made by CG, CG will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

TERMINATION OF INSURANCE - EMPLOYEES

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the end of your pay period in which your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Employer: (a) stops paying premium for you; or (b) otherwise cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends.

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, your insurance will not continue past the date your Employer stops paying premium for you or otherwise cancels the insurance.

TERMINATION OF INSURANCE - DEPENDENTS

Your insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

TERMINATION OF INSURANCE

Reinstatement of Insurance

If your Insurance ceases because you are called to active duty from status as a reservist on or after August 22, 1990, the insurance for you and your Dependents, including those born during your time of active duty, will be reinstated after your deactivation, provided you apply for reinstatement within 90 days of discharge or within one year of continuous hospitalization from the date of discharge.

Such reinstatement will be without the application of: a) a new waiting period, or b) a new Pre-existing Condition Limitation. A new Pre-existing Condition Limitation will not be applied to a condition that you or your Dependent may have developed while coverage was interrupted. However, no payment will be made for a condition that was the direct result of active military duty.

TERMINATION OF INSURANCE

CONTINUATION REQUIRED BY FEDERAL LAW FOR YOU AND YOUR DEPENDENTS

The Continuation Required by Federal Law does not apply to any benefits for loss of life, dismemberment or loss of income.

Federal law enables you or your Dependent to continue health insurance if coverage would cease due to a reduction of your work hours or your termination of employment (other than for gross misconduct). Federal law also enables your Dependents to continue health insurance if their coverage ceases due to your death, divorce or legal separation, or with respect to a Dependent child, failure to continue to qualify as a Dependent. Continuation must be elected in accordance with the rules of your Employer's group health plan(s) and is subject to federal law, regulations and interpretations.

A. Employees and Dependents Continuation Provision

If you and your Dependent's insurance would otherwise cease because of a reduction in the number of hours you work or your termination of employment for any reason other than gross misconduct, you or your Dependent may continue health insurance upon payment of the required premium to the Employer. You and your Dependents must elect to continue insurance within 60 days from the later of: (a) the date of a reduction of your work hours or your termination of employment; or (b) the date notice of the right to continue insurance is sent. Such insurance will not be continued by CG for you and/or your Dependents, as applicable, beyond the earliest of the following dates:

- 18 months from the date your work hours are reduced or your employment terminates, whichever may occur first;
- the date the policy cancels;
- the date coverage ends due to your failure to pay the required subsequent premium within 30 days of the due date;
- the date your Dependent ceases to qualify as an eligible Dependent;
- following enrollment in Medicare; for you, the date you become entitled to Medicare, and for your Dependent, the date he becomes entitled to Medicare;
- the effective date of coverage under another group health plan, unless you have a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

TERMINATION OF INSURANCE

CONTINUATION REQUIRED BY FEDERAL LAW FOR YOU AND YOUR DEPENDENTS (Continued)

B. Dependent Continuation Provision

If health insurance for your Dependents would otherwise cease because of:

(1) your death;

(2) divorce or legal separation; or

(3) with respect to a Dependent child, failure to continue to qualify as a Dependent,

such insurance may be continued upon payment of the required premium to the Employer. In the case of (2) or (3) above, you or your Dependent must notify your Employer within 60 days of such event. In addition, a Dependent must elect to continue insurance within 60 days from the later of: (a) the date the insurance would otherwise cease; or (b) the date notice of the right to continue insurance is sent.

CG will not continue the health insurance of a Dependent beyond the earliest of the following dates:

- 36 months from the date of (1), (2) or (3) above, whichever may occur first;
- the date coverage ends due to failure to pay the required subsequent premium within 30 days of the due date;
- the date the Dependent becomes entitled to Medicare, following his/her enrollment in Medicare;
- the date the policy cancels; or
- the date the Dependent becomes covered under another group health plan, unless the Dependent has a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

C. Subsequent Events Affecting Dependent Coverage

If, within the initial 18 month continuation period, your Dependent would lose coverage because of an event described in (1), (2), or (3) of Section B, or because of your coverage loss due to your subsequent entitlement to Medicare, after you have continued your Dependent's coverage due to your employment termination or reduction in work hours, your Dependent may continue coverage for up to 36 months from the date of loss of employment or reduction in work hours.

CONTINUATION REQUIRED BY FEDERAL LAW FOR YOU AND YOUR DEPENDENTS (Continued)

If your employment ends or your work hours are reduced within 18 months after your entitlement to Medicare, your covered Dependent may continue coverage for up to 36 months from the date you become entitled to Medicare.

If your employment ends or your work hours are reduced more than 18 months after your entitlement to Medicare, your covered Dependent may continue coverage for up to 18 months from the date your employment ends or your work hours are reduced.

Disabled Individuals Continuation Provisions

If you or your Dependent is disabled before or within the first 60 days of continuation of coverage which follow termination of employment or a reduction in work hours, the disabled person may continue health insurance for up to an additional 11 months beyond the 18-month period.

The disabled person may also continue the coverage for other family members continuously covered for the initial 18-month continuation period as either the Employee covering a Dependent, or as the Employee's Dependents; if they otherwise remain eligible.

To be eligible you or your Dependent must:

a) be declared disabled as of a day before or during the first 60 days of continuation, under Title II or XVI by the Social Security Administration; and

b) notify the plan administrator of the Social Security Administration's determination within 60 days following the determination and within the initial 18-month continuation period, and provide the plan administrator with a copy of the determination.

Termination of coverage for all covered persons during the 29-month period will occur if the disabled person is found by the Social Security Administration to be no longer disabled. Termination for this reason will occur on the first day of the month beginning more than 30 days after the date of the final determination.

All reasons for termination described in sections A and B which apply to the initial 18 months will also apply to any or all covered persons for any additional months of coverage.

TERMINATION OF INSURANCE

CONTINUATION REQUIRED BY FEDERAL LAW FOR YOU AND YOUR DEPENDENTS (Continued)

Conversion Available Following Continuation

If you or your Dependent's Continuation ends due to the expiration of the maximum 18-, 29- or 36-month continuation period, whichever applies, you or your Dependent may be entitled to convert to the insurance in accordance with the Medical Conversion benefit then available to Employees and their Dependents.

Interaction With Other Continuation Benefits

A person who is eligible to continue insurance under both (1) and (2) below may continue the insurance, upon payment of any required premium, for a period of time not to exceed the longer of: (1) the continuation required by federal law; or (2) any other continuation of insurance provided in this Certificate.

Newly Acquired Dependents

If, while your insurance is being continued under the continuation required by federal law provisions, you acquire a new Dependent, such Dependent will be eligible for this Continuation provided:

- the required premium is paid; and
- CG is notified of your newly acquired Dependent in accordance with the terms of the policy.

If events (1) or (2) of Section B should subsequently occur for your newly acquired Dependent spouse, such spouse will not be entitled to continue his insurance. However, your Dependent child will be able to continue his insurance.

If events described in Section C should subsequently occur for your child who is born, adopted or placed for adoption as a newly acquired Dependent, coverage will be continued according to that section.

TERMINATION OF INSURANCE

REQUIREMENTS OF FAMILY AND MEDICAL LEAVE ACT OF 1993

Any provisions of the policy that provide for: (a) continuation of insurance during a leave of absence; and (b) reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, where applicable:

A. Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

B. Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period or the requirements of any Pre-existing Condition Limitation to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993.

MEDICAL BENEFITS EXTENSION

Any expense incurred within one year after a person's Medical Expense Insurance ceases will be deemed to be incurred while he is insured if such expense is for an Injury or Sickness which causes him to be Totally Disabled from the day his insurance ceases until that expense is incurred.

The terms of this Medical Benefits Extension will not apply to (a) a child born as a result of a pregnancy which exists when a person's benefits cease; or (b) any person when he becomes insured under another group policy for medical benefits.

Totally Disabled

You will be considered Totally Disabled if, because of an Injury or a Sickness:

- you are unable to perform the basic duties of your occupation; and
- you are not performing any other work or engaging in any other occupation for wage or profit.

Your Dependent will be considered Totally Disabled if, because of an Injury or a Sickness:

- he is unable to engage in the normal activities of a person of the same age, sex and ability; or
- in the case of a Dependent who normally works for wage or profit, he is not performing such work.

ACCIDENT AND HEALTH PROVISIONS

NOTICE OF CLAIM, CLAIM FORMS and PROOF OF LOSS provisions do not apply to services or supplies recommended by and received from Participating Providers, if that service or supply is authorized by the Provider Organization.

Notice of Claim

Written notice of claim must be given to CG within 30 days after the occurrence or start of the loss on which claim is based.

If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible.

Claim Forms

When CG receives the notice of claim it will give to the claimant, or to the Policyholder for the claimant, the claim forms which it uses for filing proof of loss. If the claimant does not get these claim forms within 15 days after CG receives notice of claim, he will be considered to meet the proof of loss within 90 days after the date of loss. This proof must describe the occurrence, character and extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be given to CG within 90 days after the date of the loss for which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated nor reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

Physical Examination

CG, at its own expense, will have the right to examine any person for whom claim is pending as often as it may reasonably require.

Legal Action

No action at law or in equity will be brought to recover on the policy until at least 60 days after proof of loss has been filed with CG. No action will be brought at all unless brought within 3 years after the time within which proof of loss is required.

CONNECTICUT GENERAL LIFE INSURANCE COMPANY a CIGNA COMPANY (called CG)

CERTIFICATE RIDER

No. CR 7MI001-1

Policyholder: MARICOPA COUNTY

Rider Eligibility: Each Employee eligible under the certificate

Policy No. or Nos. 2404072-01

Effective Date: December 29, 1997

if you are in Active Service on that day, otherwise, on the date you return to Active Service. If you are not insured for the benefits described in your certificate on that date, the effective date of this certificate rider will be the date you become insured.

This certificate rider forms a part of the certificate issued to you by CG describing the benefits provided under the corresponding policy(ies).

The provisions set forth in this certificate rider comply with federal legislative requirements. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits. This certificate rider is subject to state regulatory approval.

Eligibility

The following provisions replace any similar provisions in the ''ELIGIBILITY - EFFECTIVE DATE'' section of your certificate:

Any restriction of coverage for your Dependents will not include such Dependents being Confined in a Hospital.

For plans which include a Pre-existing Condition limitation, the statement, ''CG may require evidence of good health at your expense if you are a Late Entrant'', will not prohibit you from being covered under the medical plan(s).

For plans which do not include a Pre-existing Condition limitation, you may be required to wait until the next plan enrollment period to elect coverage if you apply as a Late Entrant.

David C Kopp

Corporate Secretary

R7CEP (Cont.)

Exception to Late Entrant Definition

A person will not be considered a Late Entrant when enrolling outside a designated enrollment period if: he had existing coverage, and he certified in writing, if applicable, that he declined coverage due to other available coverage; he lost prior coverage due to the employer's failure to pay premium, he no longer qualifies in an eligible class for prior coverage, or his prior coverage ends, including continuation coverage; and he enrolls for this coverage within 30 days after losing or exhausting prior coverage. Any applicable Pre-existing Condition limitation will apply, but will not be extended as for a Late Entrant.

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption, you may enroll yourself and your Dependents provided you request enrollment by the last day of the 30-day period which begins on the day of the event. Coverage will be effective for a spouse, on the first day of the month after enrollment, and for a child, on the date of birth, adoption, or placement for adoption. If you are covered by a plan which includes a Pre-existing Condition limitation, the limitation will apply to you and your Dependents upon enrollment, reduced by prior Creditable Coverage.

Pre-existing Condition Limitation

For plans which include a Pre-existing Condition limitation, the following provisions apply under the ''Expenses Not Covered'' section of the certificate:

- for or in connection with an Injury or a Sickness which is a Pre-existing Condition after benefits equal to $750 have become payable, unless those expenses are incurred after the earlier of: (a) a consecutive 90-day period, which begins on or after the date a person begins an eligibility waiting period or becomes insured for these benefits, during which he receives no treatment, incurs no expenses and receives no diagnosis from a Physician in connection with that Injury or Sickness; or (b) a continuous, one-year period during which a person is satisfying a waiting period and/or is insured for these benefits.

Pre-existing Condition

A Pre-existing Condition is an Injury or a Sickness for which a person receives treatment, incurs expenses or receives a diagnosis from a Physician during the 90 days before the earlier of the date a person; begins an eligibility waiting period, or becomes insured for these benefits. The term Pre-existing Condition will also include any condition which is related to any such Injury or Sickness.

R7CEP (Cont.)

Extension for Late Entrant

For plans which include a Pre-existing Condition limitation, the one-year period under (b), above, will be increased to 18 months for a Late Entrant.

For plans which do not include a Pre-existing Condition limitation, you may be required to wait until the next plan enrollment period to enroll for coverage under the plan, if you are a Late Entrant.

Exceptions to Pre-existing Condition Limitation

Pregnancy, and genetic information with no related treatment, will not be considered Pre-existing Conditions.

A newborn child, an adopted child, or a child placed for adoption before age 18 will not be subject to any Pre-existing Condition limitation if such child is covered within 30 days of birth, adoption or placement for adoption. Such waiver will apply only if fewer than 63 days elapse between coverage during a prior period of Creditable Coverage and coverage under this plan.

Credit for Coverage Under Prior Plan

If a person was previously covered under a plan which qualifies as Creditable Coverage, the following will apply, provided he notifies the Employer of such prior coverage, and fewer than 63 days elapse between coverage under the prior plan and coverage under this plan, exclusive of any waiting period.

CG will reduce your Pre-existing Condition limitation period under this policy by the number of days of prior Creditable Coverage you had under a creditable health plan or policy, up to 12 months for a timely enrollee and 18 months for a Late Entrant.

R7CEP (Cont.)

Certification of Prior Creditable Coverage

You must provide proof of your prior Creditable Coverage in order to reduce a Pre-existing Condition limitation period. You should submit proof of prior coverage with your enrollment material. Certification, or other proofs of coverage which need to be submitted outside the standard enrollment form process for any reason, may be sent directly to: Eligibility Services, CIGNA HealthCare, P.O. Box 9077, Melville, NY 11747-9077. You should contact the plan administrator or CIGNA Customer Service Representative if assistance is needed to obtain proof of prior Creditable Coverage. Once your prior coverage records are reviewed and credit is calculated, you will receive a notice of your remaining Pre-existing Condition limitation period.

Creditable Coverage

Creditable Coverage will include coverage under: a self-insured employer group health plan; individual or group health insurance plans; state or federal continuation coverage; individual or group health conversion plans; Part A or Part B of Medicare; Medicaid, except coverage solely for pediatric vaccines; the Indian Health Service; the Peace Corps Act; a state health benefits risk pool; a public health plan; health coverage for current and former members of the armed forces and their Dependents; medical savings accounts; and health insurance for federal employees and their Dependents.

ERISA (Effective June 1, 1997)

The following is added to the section of the certificate/document entitled ''Summary Plan Description'':

CG will provide administrative services of the following nature: Claim Administration; Cost Containment; Financial; Banking and Billing Administration.

Benefits provided under this certificate are fully guaranteed by CG.

This certificate/document is issued by:

Connecticut General Life Insurance Company

900 Cottage Grove Road

Hartford, CT 06152

If you have questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

DEFINITIONS

Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

Bed and Board

The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

Charges

The term ''charges'' means the actual billed charges; except when the provider has contracted directly or indirectly with CG for a different amount.

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

Custodial Services

The term Custodial Services means any services which are not intended primarily to treat a specific Injury or Sickness (including mental illness, alcohol or drug abuse). Custodial Services include, but shall not be limited to:

- services related to watching or protecting a person;
- services related to performing or assisting a person in performing any activities of daily living, such as: (a) walking; (b) grooming; (c) bathing; (d) dressing; (e) getting in or out of bed; (f) toileting; (g) eating; (h) preparing foods; or (i) taking medications that can usually be self-administered; and
- services not required to be performed by trained or skilled medical or paramedical personnel.

DEFINITIONS

Dependent

Dependents are:

- your lawful spouse; and
- any unmarried child of yours who is
  - less than 19 years old.
  - 19 years but less than 25 years old, enrolled in school as a full-time student and primarily supported by you. Proof of the child's age, status as a student and dependence must be submitted to CG as of the later of his 19th birthday or the date he is enrolled for Dependent Insurance. After that, CG may require such proof at least once each year until he attains age 25.
  - 19 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to CG within 31 days after the date the child ceases to qualify above. During the next two years CG may, from time to time, require proof of the continuation of such condition and dependence. After that, CG may require proof no more than once a year.

The term child means a child born to you or a child legally adopted by you, including that child from the first day of placement in your home regardless of whether the adoption has become final. It also includes a stepchild who lives with you.

Anyone who is eligible as an Employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one Employee.

Durable Medical Equipment

The term Durable Medical Equipment means equipment which:

- can withstand repeated use;
- is primarily and customarily used to serve a medical purpose;
- is generally not useful to a person in the absence of Sickness or Injury; and
- is appropriate for use in the home.

DEFINITIONS

Emergency Services

Emergency Services are medical, surgical, Hospital and related health care services, including ambulance service, required for the alleviation of severe pain or to treat an Injury or a sudden, unexpected onset of a serious Sickness which, if not treated immediately, may result in serious medical complications, loss of life or permanent impairment to bodily functions. Included are conditions which produce loss of consciousness or excessive bleeding; or which may otherwise be determined by the Provider Organization, in accordance with generally accepted medical standards, to have been an acute condition requiring immediate medical attention.

Employee

The term Employee is as defined by your Employer.

Employer

The term Employer means the Policyholder and all Affiliated Employers.

Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.

Free-Standing Surgical Facility

The term Free-standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

DEFINITIONS

Home Health Care Agency

The term Home Health Care Agency means a Hospital or a non-profit or public home health care agency which:

- primarily provides skilled nursing service and other therapeutic service under the supervision of a Physician or a Registered Graduate Nurse;
- is run according to rules established by a group of professional persons;
- maintains clinical records on all patients;
- does not primarily provide custodial care or care and treatment of the mentally ill;

but only if, in those jurisdictions where licensure by statute exists, that Home Health Care Agency is licensed and run according to the laws that pertain to agencies which provide home health care.

Hospice Care Program

The term Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

Hospice Care Services

The term Hospice Care Services means any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Care Agency, (d) a Hospice Facility, or (e) any other licensed facility or agency under a Hospice Care Program.

Hospice Facility

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by CG; and
- fulfills any licensing requirements of the state or locality in which it operates.

DEFINITIONS

Hospital

The term Hospital means:

- an institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals; or
- an institution which: (a) specializes in treatment of mental illness, alcohol or drug abuse or other related illness; (b) provides residential treatment programs; and (c) is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician; or
- Partially Confined for treatment of: (a) mental illness; (b) alcohol or drug abuse; or (c) other related illness. To determine benefits payable, two days of being Partially Confined in a Hospital will be equal to one day of being Confined in a Hospital.

The term Partially Confined means continually treated for at least 3 hours but not more than 12 hours in any 24-hour period.

In-Network/Out-of-Network

The term In-Network refers to care which is authorized by a person's Primary Care Physician and by the Provider Organization. In the case of mental illness, alcohol or drug abuse treatment, other than Hospital Confinement solely for detoxification, authorization by the Primary Care Physician will be waived.

The term Out-of-Network refers to care which does not qualify as In-Network.

Emergency care which meets the definition of Emergency Services and is authorized as such by either the Primary Care Physician or the Provider Organization is considered In-Network. (For details, refer to the Designated Provider Medical Benefits coverage section.)

DEFINITIONS

Injury

The term Injury means an accidental bodily injury.

Late Entrant

You are a Late Entrant for Employee or Dependent Insurance if:

(a) you have not been continuously covered for one year under a group medical insurance policy or a self-insured group medical plan, other than a policy issued by a state high risk insurance pool; and

(b) you have declined medical coverage for yourself or your Dependents through your Employer during the initial enrollment period, or have ended your coverage at any time; and

(c) you later request coverage for yourself or your Dependents.

The initial enrollment period must have been at least 30 days. An individual is not considered a Late Entrant if one of the following applies:

1. The person, at the time of the initial enrollment period, was covered under a prior plan. ''Prior plan'' means a public or private group medical insurance policy or self-insured group medical plan.
2. The person lost coverage under the prior plan due to the Employee's termination of employment or eligibility, the termination of the prior plan's coverage, the death of the spouse, or divorce.
3. The person requests enrollment within 30 days after the termination of coverage provided under the prior plan.
4. The person is employed by an Employer that offers multiple medical plans and the person elects a different plan during an open enrollment period.
5. A court orders that coverage be provided for a spouse or minor child under a covered Employee's medical plan and the Employee requests enrollment within 30 days after the court order is issued.

''Continuously covered'' means the person is covered at the beginning and the end of the period and has not had any breaks in coverage during the period totaling more than 31 days.

Mail-Order Pharmacy

The term Mail-Order Pharmacy means a pharmacy designated as a primary distribution center for a mail-service program.

DEFINITIONS

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Mental Illness

The term ''mental illness'' means any disorder, other than a disorder induced by alcohol or drug abuse, which impairs the behavior, emotional reaction or thought process of a person, regardless of medical origin. In determining benefits payable, charges made for the treatment of any physiological symptoms related to a mental illness will not be considered to be charges made for treatment of a mental illness.

Necessary Services and Supplies

The term Necessary Services and Supplies includes any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation ''R.N.,'' ''L.P.N.'' or ''L.V.N.''

Participating Mail-Order Pharmacy

The term Participating Mail-Order Pharmacy means a Mail-Order Pharmacy which has contracted directly or indirectly with Connecticut General Life Insurance Company on behalf of RxPRIME.

Participating Provider

The term Participating Provider means:

- an institution, facility, agency or health care professional which has contracted directly or indirectly with CG.

The providers qualifying as Participating Providers may change from time to time. A list of the current Participating Providers will be provided by the Employer.

DEFINITIONS

Participating Retail Pharmacy

The term Participating Retail Pharmacy means a Retail Pharmacy which has contracted directly or indirectly with Connecticut General Life Insurance Company on behalf of RxPRIME.

Pharmacy

The term Pharmacy means a licensed establishment where prescription drugs are dispensed by a pharmacist.

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

Prescription Legend Drug

The term Prescription Legend Drug means any medicinal substance requiring, under the Federal Food, Drug and Cosmetic Act, a label that reads: ''Caution: Federal law prohibits dispensing without a prescription.''

Prescription Order

The term Prescription Order means the request for each separate drug or medication by a Physician or each authorized refill of such request.

Primary Care Physician

The term Primary Care Physician means a Physician: (a) who qualifies as a Participating Provider in general practice, internal medicine, family practice or pediatrics; and (b) who has been selected by you, as authorized by the Provider Organization, to provide or arrange for medical care for you or any of your insured Dependents.

Provider Organization

The term Provider Organization refers to a network of Participating Providers.

DEFINITIONS

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include: (1) any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is: (a) operating within the scope of his license; and (b) performing a service for which benefits are provided under this plan when performed by a Psychologist; and (2) any psychotherapist while he is providing care authorized by the Provider Organization if he is: (a) state licensed or nationally certified by his professional discipline; and (b) performing a service for which benefits are provided under this plan when performed by a Psychologist.

Reasonable and Customary Charge

A charge will be considered Reasonable and Customary if:

- it is the normal charge made by the provider for a similar service or supply; and
- it does not exceed the normal charge made by most providers of such service or supply in the geographic area where the service is received, as determined by CG.

To determine if a charge is Reasonable and Customary, the nature and severity of the Injury or Sickness being treated will be considered.

Retail Pharmacy

The term Retail Pharmacy means any pharmacy other than a pharmacy designated as a primary distribution center for a mail service program.

Sickness - For Medical Insurance

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

DEFINITIONS

Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of Physicians; and (c) provides Nurses' services.

Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

Synopsis for job U52275C [MMB] Requested by: JCF

Composed on 24-AUG-98 at 15:11 with 1 error.

Job: U52275C Account name: MARICOPA COUNTY
Account number: 2404072 Policyholder Category: RG
Job type: GBC6 Job category: NEW Job style: S
Region: 1 Group office: Type of business: X
Budget code: 8C30 Quantity: 1038 Due date:

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3	CER5 (E)	28	FLX106V48 (E)
4	NOTICE	29	FLX107
5	DPP1 (E)	30	FLX108V29 (E)
6	DPP1 (E) cont.	31	FLX108V102 (E)
7	DPP2 (E)	32	FLX124V4
8	DPP2 (E) cont.	33	FLX124V5(1) (E)
9	DPP3 (E)	34	FLX124V5(2) (E)
10	DPP3 (E) cont.	35	FLX110V11 (E)
11	DPP4 (E)	36	FLX111V28 (E)
12	SPC1V29 (E)	37	FLX113V18
13	SPC15V29 (E)	38	PRE1V171 (E)
14	RXRETAIL (E)	39	PRE2V3 (E)
15	SCT125A	40	PRE3V67 (E)
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17	CLA9V14 (E)	42	CON5
18	ELI5 (E)	43	CON26
19	ELI7	44	CON29
20	ELI11V12	45	GEN18V2 (E)
21	ELI98V1	46	GEN246V4 (E)
22	HEA1	47	GEN253V3 (E)
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DEFINITION SYNOPSIS: